

## § 405.450

(2) Notify all Medicare carriers, with which he or she filed an affidavit, of the termination of the opt-out no later than 90 days after the effective date of the opt-out period.

(3) Refund to each beneficiary with whom he or she has privately contracted all payment collected in excess of:

(i) The Medicare limiting charge (in the case of physicians); or

(ii) The deductible and coinsurance (in the case of practitioners).

(4) Notify all beneficiaries with whom the physician or practitioner entered into private contracts of the physician's or practitioner's decision to terminate opt-out and of the beneficiaries' right to have claims filed on their behalf with Medicare for the services furnished during the period between the effective date of the opt-out and the effective date of the termination of the opt-out period.

(c) When the physician or practitioner properly terminates opt-out in accordance with paragraph (b), he or she will be reinstated in Medicare as if there had been no opt-out, and the provision of § 405.425 shall not apply unless the physician or practitioner subsequently properly opts out.

(d) A physician or practitioner who has completed opt-out on or before January 1, 1999 may terminate opt-out during the 90 days following January 1, 1999 if he or she notifies all carriers to whom he or she would otherwise submit claims of the intent to terminate opt-out and complies with paragraphs (b)(3) and (4) of this section. Paragraph (c) of this section applies in these cases.

### § 405.450 Appeals.

(a) A determination by CMS that a physician or practitioner has failed to properly opt-out, failed to maintain opt-out, failed to timely renew opt-out, failed to privately contract, or failed to properly terminate opt-out is an initial determination for purposes of § 405.803.

(b) A determination by CMS that no payment can be made to a beneficiary for the services of a physician who has opted-out is an initial determination for purposes of § 405.803.

## 42 CFR Ch. IV (10–1–05 Edition)

### § 405.455 Application to Medicare+Choice contracts.

An organization that has a contract with CMS to provide one or more Medicare+Choice (M+C) plans to beneficiaries (part 422 of this chapter):

(a) Must acquire and maintain information from Medicare carriers on physicians and practitioners who have opted-out of Medicare.

(b) Must make no payment directly or indirectly for Medicare covered services furnished to a Medicare beneficiary by a physician or practitioner who has opted-out of Medicare.

(c) May make payment to a physician or practitioner who furnishes emergency or urgent care services to a beneficiary who has not previously entered into a private contract with the physician or practitioner in accordance with § 405.440.

### Subpart E—Criteria for Determining Reasonable Charges

**AUTHORITY:** Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

**SOURCE:** 32 FR 12599, Aug. 31, 1967, unless otherwise noted. Redesignated at 42 FR 52826, Sept. 30, 1977.

### § 405.500 Basis.

Subpart E is based on the provisions of the following sections of the Act: Section 1814(b) provides for Part A payment on the basis of the lesser of a provider's reasonable costs or customary charges. Section 1832 establishes the scope of benefits provided under the Part B supplementary medical insurance program. Section 1833(a) sets forth the amounts of payment for supplementary medical insurance services on the basis of the lesser of a provider's reasonable costs or customary charges. Section 1834(a) specifies how payments are made for the purchase or rental of new and used durable medical equipment for Medicare beneficiaries. Section 1834(b) provides for payment for radiologist services on a fee schedule basis. Section 1834(c) provides for payments and standards for screening mammography. Section 1842(b) sets forth the provisions for a carrier to enter into a contract with the Secretary and to make determinations